DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155688	B. WIN			08/01/2	011
		<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		1	CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME		1	ANDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification	K(0000	By submitting the enclosed	r the	
	and State Licensure Survey was				material we are not admitting the truth or accuracy of any specific		
	conducted by t	he Indiana State			findings or allegations. We	51110	
	Department of	Health in			reserve the right to contest the	he	
	•	h 42 CFR 483.70(a).			findings or allegations as par any proceedings and submit	rt of	
	Survey Date: 0	8/01/11			these responses pursuant to regulatory obligations. The f requests that the plan of		
	Facility Number	r: 000355			correction be considered our		
	Provider Number: 155688				allegation of compliance to t		
					Life Safety Code Recertificat		
	AIM Number: 1	100273640			Survey conducted on Augus 2011.	t 1,	
	Surveyor: Lex	Brashear, Life Safety					
	Code Specialist	·					
	Code Specialise	•					
		ety Code survey,					
		ommunity Home					
	was found not	in compliance with					
	Requirements f	for Participation in					
	Medicare/Medi	caid, 42 CFR					
	Subpart 483.70	O(a), Life Safety					
	<u> </u>	he 2000 edition of					
	the National Fir						
		FPA) 101, Life Safety					
	•						
		410 IAC 16.2. The					
	_	ig was surveyed					
	-	9, Existing Health					
	Care Occupanc	ies.					
	This one story	facility with a					
	-	determined to be of					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZDIX21

Facility ID:

000355

If continuation sheet

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155688	B. WINC			08/01/2	011
NAME OF B	DOWNER OF CHIRD IED				DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				CARLISLE ST		
	NDVILLE COMMUN				ANDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES	Ι,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	COMPLETION DATE
mo		·		mo	·		DATE
		onstruction and was					
	fully sprinklered. The facility has a fire alarm system with smoke						
	· ·						
	detection in the						
	-	the corridors. The					
		spacity of 50 and					
		f 35 at the time of					
	this survey.						
	Quality Daviasy by I	Dobart Booker Life Safety					
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/09/11.						
	The facility was	found not in					
	compliance wit	h the					
	aforementioned	d regulatory					
	requirements a	s evidenced by the					
	following:	·					
K0018	Doors protecting o	corridor openings in other					
SS=F	than required encl	osures of vertical openings,					
	· ·	s areas are substantial					
		se constructed of 1¾ inch wood, or capable of					
		least 20 minutes. Doors in					
	sprinklered buildin	gs are only required to					
		of smoke. There is no					
	•	closing of the doors. Doors a means suitable for					
		closed. Dutch doors					
	meeting 19.3.6.3.6						
	Dollar letek	prohibited by CMC					
	Roller latches are prohibited by CMS regulations in all health care facilities.						
	Based on observation and	K0	018	K018 It is the practice of		08/31/2011	
					Freelandville Community Home		
	interview, the facility failed to ensure 3 of 3 clean linen closets				to assure that the linen clos	ets	
		ors were equipped			with double doors are		
	with double do	ors were equipped					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID: 000355

If continuation sheet

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED	
		155688	B. WIN	IG		08/01/2011	
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
				1	CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME		FREEL	ANDVILLE, IN47535		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(XS	
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATI	E
	with positive latches in 3 of 4				equipped with positive late in smoke compartments for	I	
	smoke compar	tments. This			protection of the residents,	lile	
	deficient practi	ice could affect all			visitors, and staff. It is also	our	
	residents, as w	ell as staff and			practice to assure that all		
	visitors.				resident doors are smoke		
	V1510015.				resistant and close properly	<i>,</i> .	
	Finalina - 1!	la.			The correction action taker	· I	
	Findings includ	ie:			those residents found to be	.	
					affected by the deficient		
	Based on obse	rvations on			practice include: There are	I	
	08/01/11 between 10:45 a.m. and				specific residents identified.	I	
	1:30 p.m. during a tour of the				linen closet doors on A, B, and halls have been corrected. I		
	facility with the Maintenance				addition, the door to room #7		
	Supervisor, all three sets of clean				been corrected. <i>Other resid</i>		
	l				that have the potential to b		
		uble doors in the A,			affected have been identifie	I	
		were not equipped			by: Potentially all residents of	ould	
	with positive la	itches. This was			be effected. All resident room		
	acknowledged	by the Maintenance			doors have been checked ar		
	Supervisor at t	he time of each			corrected if needed. All doul	-	
	observation.				doors throughout the building have been reviewed to assure		
					that positive latches are in pl		
	3.1-19(b)				as required. The measures	I	
	3.1 13(0)				systematic changes that ha	I	
					been put into place to ensu	re	
	2. Based on ol				that the deficient practice of	oes	
	· ·	facility failed to			not recur include: The		
	ensure 1 of 27	resident room			assessment of doors through		
	doors would cl	ose completely and			the building has been placed preventive maintenance sche	I	
	was smoke res	istant. This			to assure that all doors work	I	
	deficient practi	ice could affect any			accordance with the regulation		
	· ·	ents, as well as			The Maintenance Supervisor	I	
		errs in the A hall.			been in-serviced related to the	is	
	j stari anu visitu	is in the A hall.			review and assuring that	.,	
					corrections are implemented	it	
	Findings includ	de:			there are any findings. The corrective action taken to		
					Corrective action taken to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155688	B. WING			08/01/2	011
			P. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CARLISLE ST		
	NDVILLE COMMUN	NITY HOME			ANDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG			DATE
	Based on obser				monitor performance to ass		
	08/01/11 at 12:35 p.m. during a tour of the facility with the Maintenance Supervisor, resident room door # 7 did not close completely because the top hinge			compliance through quality assurance is: The proper			
					functioning and latching of do	oors	
					will be monitored as part of the	ne	
					preventive maintenance revie		
					the quarterly QA meetings.	Γhe	
	of the door was				Maintenance Director, or designee, will be responsible	for	
	screws which caused the door to				assuring all doors throughou		
	droop. This caused a one half inch gap between the door and its frame when closed. This was acknowledged by the Maintenance				building are reviewed on a		
					quarterly basis for proper		
					functioning and latching. Any	У	
					identified issues will be immediately corrected. The		
					Administrator, or designee, w	/ill	
	Supervisor at th	ne time of			review the preventive		
	observation.				maintenance documentation		
					quarterly for compliance. The		
	3.1-19(b)				date the systemic changes be completed: August 31, 20		
K0021	Any door in an exi	t passageway, stairway					
SS=E		ntal exit, smoke barrier or					
		nclosure is held open only					
		ed to automatically close all e or throughout the facility					
	upon activation of:	•					
	a) the required ma	nual fire alarm system;					
	b) local smoke det	tectors designed to detect					
		ough the opening or a					
	required smoke de	etection system; and					
	c) the automatic si	prinkler system, if installed.					
	19.2.2.2.6, 7.2.1.8						
	Based on obser		K0	0021	K021 It is the practice of Freelandville Community H	ome	10/31/2011
	interview, the f	-			to assure that doors between		
	ensure 1 of 7 d	loors between			smoke barriers are provided		
	smoke barriers	was provided with			with self-closures to ensure		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DING	01	COMPL	ETED
		155688	A. BUIL B. WING			08/01/2	011
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			CARLISLE ST		
FRFFI AI	NDVILLE COMMUN	JITY HOME			ANDVILLE, IN47535		
			$\overline{}$,		975)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
1110				1110	that doors will automatical		Ditte
	a self closer to ensure the door				close as required. The	,	
	would close automatically or upon				correction action taken for		
	activation of the fire alarm system				those residents found to b	e	
	or automatic sprinkler system.				affected by the deficient		
	This deficient practice could affect				practice include: There are		
	any of the 35 r	esidents, as well as			specific residents identified. attic access door from the di		
	staff and visito	rs while in the			room will have a self-closure	٠ ١	
	Dining Room.				installed once the door is		
					received. The facility is havi		
	Findings includ	le:			special size door individually	'	
	Tindings melade.				made for this area. Other residents that have the		
	Based on obse	rvation on			potential to be affected have	,	
					been identified by: Potentia		
		2:55 p.m. during a			residents could be effected.	·	
	tour of the faci				doors that could require		
		upervisor, the attic			self-closures have been revi		
	-	door from the			and corrected if needed. The	e	
	Dining Room w	as not equipped			measures or systematic changes that have been pu	,,	
	with a self clos	er to ensure the			into place to ensure that th		
	door would clo	se automatically or			deficient practice does not		
	in the event the	e fire alarm system			recur include: The doors the	at	
	or the sprinkle	r system is			require review related to	.	
		was acknowledged			self-closing have been place the preventive maintenance	a on	
		ance Supervisor at			schedule for quarterly reviev	v.	
	the time of obs				The Maintenance Director ha		
	the time of obs	ici vacioni			been in- serviced related to	the	
	2 1 10/b)				following of the preventive		
	3-1.19(b)				maintenance plan and assur		
					that all necessary doors hav self-closure as required by the		
					regulations. <i>The corrective</i>		
					action taken to monitor		
					performance to assure		
					compliance through quality		
					assurance is: The review of		
					doors requiring self-closures	WIII	
			1				

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON	ISTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	
		155688	B. WINC	·		08/01/2	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
FREELAI	NDVILLE COMMUN	IITY HOME			NDVILLE, IN47535		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
K0025 SS=E	least a one half ho accordance with 8 terminate at an atr protected by fire-ra glass panels and s two separate compleach floor. Dampe penetrations of sm heating, ventilating	e constructed to provide at our fire resistance rating in an analysis. Smoke barriers may ium wall. Windows are ated glazing or by wired steel frames. A minimum of coartments are provided on ours are not required in duct tooke barriers in fully ducted an air conditioning 7.3, 19.3.7.5, 19.1.6.3,			be monitored as part of the preventive maintenance reviet the quarterly QA meetings. The quarterly QA meetings. Maintenance Director, or designee, will be responsible assuring that the self closure completed in accordance with schedule. Any identified issured will be immediately corrected. The Administrator, or designed will review the preventive maintenance documentation quarterly for compliance. The date the systemic changes be completed: The facility respectfully requests an extension to extend the date certain because of awainting arrival of new custom made for that will take 5-6 weeks time to manufacture and 4 with the deliver. A safety round has been implemented daily to as awareness of hazard. The estimated time of correction in October 31, 2011.	The for s are h the les l. ee, will fire lead eeks s sssure	
	Based on obser interview, the f		K0	025	K025 Iti is tihe practice off tihis ffacilitiy	tio	08/31/2011
		moke barrier walls			assure tihati smoke barrier walls		
	chaule I UI 3 3	more parrier wans			provide ati leasti ½ hour ffre		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID: 000355

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155688		A. BUI	LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/01/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CARLISLE ST ANDVILLE, IN47535	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	fire resistance in the smoke b were not fire st deficient practi of the 35 residustaff and visito during time specific Room or the froom. Findings include Based on obsertion of the faci Maintenance Susmoke barrier of the faci smoke barrier of the faci compartment here the penetrations the smoke that the second seco	ce could affect any ents, as well as rs in the facility ent in the Dining ont lounge/TV e: e: e: e: e: e: e: e: e: e			resistiance in accordance with ticode. The correcton acton taken fior those residents flound to be affect by the deficient practice include: There are no specific residents identified on C hall has been repaired. Other residents that have the potental to be affected have been identified by: Pottenttally all residents could be effectted All barrier walls have be reviewed tto assure tthatt there appenetizations in the barrier. The measures or systemate changes that have been put into place to ensure that the deficient practice does not recur include: Barrier walls have been added to preventive mainttenance program quartterly reviews. The mainttenance in the following off the preventive mainttenance plan. The corrective acton taken to monitor performance to assure compliance through quality assurance is: The barrier wall reviews will be monittored as partt off the prevention of	teted n e een are no t tthe n ftor nnce e enttve rtterly

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155688	B. WING			08/01/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME			LANDVILLE, IN47535		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Administtrattoror designee, will		
					review tthe preventtve mainttenar	nce	
					documenttatton quartterly ftor		
					compliance.		
					The date the systemic changes wi	11	
					be completed:		
					Augustt31, 2011		
K0027		smoke barriers have at least					
SS=E	·	rotection rating or are at solid bonded wood core.					
		ve plates that do not exceed					
	·	bottom of the door are					
		ntal sliding doors comply					
	•	ors are self-closing or					
		in accordance with					
	19.2.2.2.6. Swing	ing doors are not required					
	to swing with egre	ss and positive latching is					
	not required. 19	0.3.7.5, 19.3.7.6, 19.3.7.7					
	Based on obser	vation and	K0	027	K027 It is the practice of		10/31/2011
	interview, the f	acility failed to			Freelandville Community H		
	ensure 1 of 7 d	•			to assure that doors between		
		was at least a 20			smoke barriers are at least		
					minute fire rated door or at		
		ed door or at least a			least a 1 3/4 inch thick solid		
	1 3/4-inch thic	ck solid bonded			bonded wood core door. The	-	
	wood core doo	r. This deficient			correction action taken for those residents found to be		
	practice could	affect any of the 35			affected by the deficient	•	
	residents, as w	•			practice include: There are	no	
		the Dining Room.			specific residents identified.		
	VISILOIS WITHE II	Tale Dilling Room.			stairway door to the attic from		
					dining room is being replace		
	Findings includ	le:			with at least a 20 minute fire	rated	
					door. This door has to be		
	Based on obser	vation on			especially made because of		
		2:55 p.m. during a			size of the door. Other resid		
	tour of the faci	_			that have the potential to be		
		•			affected have been identified		
	Maintenance Su	•			by: Potentially all residents of be effected. All smoke barrie		
	stairway door t	o the attic from the			doors have been reviewed to		
					GOOIS HAVE DECITIEVIEWED TO	•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ		INSTRUCTION 01	(X3) DATE SURVEY COMPLETED			
		155688	A. BUII B. WIN			08/01/2011		
	PROVIDER OR SUPPLIER		P. WEN	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST FREELANDVILLE, IN47535				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL I. S.C. IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
TAG	Dining Room w	ipervisor at the		TAG	assure that they have proper ratings. Please refer to syste implemented to assure compliance with this tag. The measures or systematic changes that have been purinto place to ensure that the deficient practice does not recur include: The smoke be doors have been added to the preventive maintenance progon a quarterly basis to assure they work properly and have proper fire resistance. The maintenance Director has be in-serviced related to the following of the preventive maintenance plan. The corrective action taken to monitor performance to assurance is: The smoke be doors will be monitored as pathe preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that barrier doors are of the proper rating. Any identified issues be immediately corrected. The Administrator, or designee, we review the preventive maintenance documentation quarterly for compliance. The date the systemic changes be completed: The facility respectfully requests an extention to extend the date certain. This door had to be custom made because of the size. This will take 5-6 week	t e arrier e gram e that een sure r arrier art of the er fire will he will e e will		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155688	B. WING		08/01/2011
NAME OF I	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE	
FRFFI A	NDVILLE COMMUN	IITY HOME	I	CARLISLE ST LANDVILLE, IN47535	
				1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· `		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K0029 SS=E	One hour fire rated construction (with ¾ hour			manufacture and another 4 weeks for deliverly. A safety round has been implemente daily to assure awareness of hazard. The estimated time correction is October 31, 20	/ d f of
	Based on obser interview, the fensure 3 of 6 heroom doors sud square feet concombustible made equipped with on the doors. practice could a residents, as we visitors in all the corridors. Findings includes Based on obser 108/01/11 between 108 of	acility failed to lazardous area ch as rooms over 50 litaining laterial were self closing devices This deficient laffect any of the 35 lell as staff and liree sleeping room le: le: levations on leen 10:45 a.m. and ling a tour of the	K0029	K029 It is the practice of Freelandville Community H to assure that doors to hazardous areas over 50 square feet that contain combustible material have self-closing devices. The correction action taken for those residents found to be affected by the deficient practice include: There are specific residents identified. 3 doors identified in the 256's being replaced because the self-closing devices that wer installed did not work proper the doors. These doors have been ordered and are expect be available for installation in approximately 6 weeks. Oth residents that have the potential to be affected have been identified by: Potential	no The 7 are re re reted to n reer

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155688 08/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 310 W CARLISLE ST FREELANDVILLE COMMUNITY HOME FREELANDVILLE, IN47535 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE residents could be effected. All Supervisor, the following doors that are present in hazardous area room doors were hazardous areas have been not provided with self closing reviewed to assure that they have self-closing devices in place. devices: the A, B, and C hall Please refer to systems shower rooms which each implemented to assure contained two soiled linen barrels compliance with this tag. The over thirty two gallons total measures or systematic capacity containing soiled linen. changes that have been put into place to ensure that the This was acknowledged by the deficient practice does not Maintenance Supervisor at the recur include: The doors to the time of each observation, hazardous areas have been furthermore, the Maintenance added to the preventive maintenance program on a Supervisor indicated the soiled quarterly basis to assure that they linen barrels were normally kept in have properly working self-closing the three shower rooms. devices. The maintenance Director has been in- serviced related to the following of the 3.1-19(b)preventive maintenance plan. The corrective action taken to monitor performance to assure compliance through quality assurance is: The doors to the hazardous areas will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that the self-closing devices on the doors function properly. Any identified issues will be immediately corrected. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance. The date the systemic changes will be completed: The facility

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	01	COMPL	ETED
		155688	B. WING			08/01/2	011
				TREET AD	DDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIER		3	10 W C	ARLISLE ST		
	NDVILLE COMMUN				NDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES	1	D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	1	EFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
K0038 SS=E	Exit access is arrareadily accessible with section 7.1. Based on obserinterview, the fensure 2 of 6 ethe existing but delayed egress with signs indic ALARM SOUND OPENED IN 15 from their mag 15 seconds after panic bar. LSC approved, lister locks shall be prinstalled on doordinary hazard buildings prote an approved, si automatic fire caccordance with approved, supersprinkler system with Section 9.5	acility failed to xit access doors in ilding supplied with locks and provided cating PUSH UNTIL S DOOR CAN BE SECONDS, released netic holders within er pushing the 7.2.1.6.1, says d, delayed-egress permitted to be ors serving low and d contents in ceted throughout by upervised detection system in th Section 9.6, or an ervised automatic m in accordance	K003	88 · · · · · · · · · · · · · · · · · ·	respectfully requests aan extention to extend the date certain. Doors and frames had be ordered. This will take 6 weeks for deliverly and installation. A safety round has been implemented daily assure awareness of hazard estimated time of correction October 31, 2011. K038 It is tihe practice off Freelandville Community Home tio assure that exiti doors release properly as a delayed egress in accordance with the regulation The correcton acton taken fior those residents fiound to be affect by the deficient practice include: There are no specific residentts identified. The doors identified on hall and tithe Dining Room have had Relay Swittches replaced and now work appropriattely Other residents that have the potental to be affected have been identified by: Pottenttally all residentts could be effectted. All exitt doors have been reviewed the assure that tithe delegress locks work appropriattely. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The doors identified as exitt areas being reviewed tto assure that	und to . The is enti	08/31/2011

000355

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	01	COMPL	
		155688	B. WIN	NG		08/01/2	011
NAME OF 1	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE	-	
					CARLISLE ST		
FREELA	NDVILLE COMMUI	NITY HOME		FREEL	ANDVILLE, IN47535		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
	I	he following criteria			delayed egress locks are working		
	are met: (a) Th	e doors shall unlock			properly as partt oft tthe preventt mainttenance plan on a quartterly		
	upon actuation	n of an approved,			basis The mainttenance Directtor		
	supervised aut	omatic sprinkler			been in- serviced relatted tto tthe		
	system in acco	rdance with Section			ftollowing oft tthe preventtve		
	9.7 or upon th	e actuation of any			mainttenance plan		
	heat detector of	or activation of not			The correctve acton taken to		
	more than two	smoke detectors of			monitor perfiormance to assure		
	an approved, s				compliance through quality assurance is:		
	1	detection system in			The delayed egress locks att tthe	evitt	
		th Section 9.6. (b)			areas will be monittored as partt of		
		II unlock upon loss			tthe preventtve mainttenance rev		
		olling the lock or			att tthe quartterly QA meettng§h	e	
	· ·				Mainttenance Directtoror designe	e,	
	locking mecha				will be responsible ftor assuring tt		
	•	ocess shall release			tthe delayed egress locks on tthe		
		15 seconds upon			doors are operating properly. Any		
	application of				identtfted issues will be immediat correctted The Administtrattgror	tery	
	release device	•			designee, will review the prevent	tve	
	7.2.1.5.4 that				mainttenance documenttatton		
	required to ex	ceed 15 lbf nor be			quartterly ftor compliance		
	required to be	continuously			The date the systemic changes w	ill	
	applied for mo	re than 3 seconds.			be completed:		
	The initiation of	of the release			Augustt31, 2011		
	process shall a	ctivate an audible					
	signal in the vi	cinity of the door.					
	Once the door	•					
	released by the	e application of					
	force to the re	• •					
	relocking shall	-					
	_	xception: Where					
	I	ne authority having					
	1	· · · · · · · · · · · · · · · · · · ·					
	1 *	delay not exceeding					
	30 seconds sh	all be permitted. (d)					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688		ULTIPLE CO LDING	onstruction 01	(X3) DATE COMPL	ETED
		100000	B. WIN			06/01/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CARLISLE ST		
FREELA	NDVILLE COMMUN	IITY HOME		1	ANDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
1710	On the door ad		+	1110			DITTE
	·	e, there shall be a					
	readily visible,						
	· ·	than 1 inch high					
	and not less th						
	stroke width or	·					
		at reads as follows:					
	PUSH UNTIL AL	ARM SOUNDS					
	DOOR CAN BE	OPENED IN 15					
	SECONDS. This	deficient practice					
	could affect an	y of the 35					
	residents, as w	ell as staff and					
	visitors while ir	the Dining Room.					
	Findings includ	e:					
	Based on obser	vation on					
		een 10:45 a.m. and					
	1:30 p.m. durir	ng a tour of the					
	facility with the	Maintenance					
	Supervisor, the	C hall exit door					
	and the Dining	Room middle exit					
	door were both	equipped with					
	delayed egress	locks with signs					
	indicating PUSH	I UNTIL ALARM					
	SOUNDS DOOR	CAN BE OPENED IN					
	15 SECONDS.	These doors did not					
	release from th	•					
	holders within						
		owever, they both					
	did release whe	<u> </u>					
	code was push						
	acknowledged	by the Maintenance					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 01			(X3) DATE SURVEY COMPLETED		
AND I LAN	or connection	155688	A. BUII			08/01/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	CARLISLE ST		
	NDVILLE COMMUN				ANDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1110	Supervisor at th	· · · · · · · · · · · · · · · · · · ·	+	1710			DITTE
	observation.	ie tille of each					
	observation.						
	3.1-19(b)						
K0050 SS=C	varying conditions, shift. The staff is f is aware that drills routine. Responsi conducting drills is competent persons exercise leadershic conducted betwee announcement manudible alarms. Based on recordinterview, the fact that is a staff of the shifts during 4 deficient practions and the shifts in the shifts	s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 d review and acility failed to s were held at r 1 of 3 employee of 4 quarters. This ce could affect all e facility. e:	K	0050	K050 Iti is tihe practice off tihis ffacilitive assure tihati ffre drills are conducted ati leasti quartierly on each shiff. The correcton acton taken fior those residents fiound to be affect by the deficient practice include: There are no specific residentts identified. Please see under systice implemented to assure compliant with this ttag. Other residents that have the potental to be affected have been identified by: Pottenttally all residentts could be effectted. Please refter the systicm implemented the assure compliant with this ttag. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:	ems nce	08/31/2011

Facility ID:

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	01	COMPI	LETED
		155688	1			08/01/2	.011
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
			310 W CARLISLE ST				
FREELA	NDVILLE COMMUI	NITY HOME		FREEL/	ANDVILLE, IN47535		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	,,,	DATE
	record review.	the Maintenance			each shift per quartter in2011. Th	e	
	·	nowledged the			ftre drills are scheduled per tthe		
	l '	-			preventtve mainttenance schedul	e tto	
		ır second shift fire			be held each shift quartterly. The		
	drills.				Mainttenance Directtor has been	in	
					serviced relatted tto tthe sttagger	ing oft	
	3-1.19(b)				ttmes witthin tthe required shifts	tto	
					inittatte tthe ftre drills		
					The correctve acton taken to		
					monitor perfiormance to assure		
					compliance through quality		
					assurance is:		
					The ftre drills will be monittored a	ıs	
					partt oft tthe preventtve maintten	ance	
					review att tthe quartterly QA		
					meettngs. The Mainttenance		
					Directtor or designee, will be		
					responsible ftor assuring tthatt tth	ne ftre	
					drills are completted in accordanc	e	
					witth tthe schedule and tthatt shif	ts are	
					appropriattely sttaggered Any		
					identtfted issues will be immediat	tely	
					correctted The Administtrattgror		
					designee, will review tthe prevent	tve	
					mainttenance documenttatton		
					quartterly ftor compliance		
					The date the systemic changes w	ill	
					be completed:		
			1		Augustt31, 2011		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZDIX21

Facility ID: 000355

If continuation sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING B. WING 01			LETED		
	PROVIDER OR SUPPLIER			310 W (ADDRESS, CITY, STATE, ZIP CODE CARLISLE ST ANDVILLE, IN47535		
	SUMMARY S (EACH DEFICIENT REGULATORY OR A fire alarm syster components, devive according to NFP/COde, to provide of any part of the built complete fire alarm alarm initiation, at extinguishing system patient sleeping provided that man 200 feet of nurse's located in the path written records of reliable second so Fire alarm system accordance with N maintenance are list remote annunci system to an apprenance of the properly test at fire alarm system with NFPA 72. allows fire alar components to equipment or contained and systems,	STATEMENT OF DEFICIENCIES (CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) m with approved ces or equipment is installed A 72, National Fire Alarm effective warning of fire in ilding. Activation of the m system is by manual fire utomatic detection or em operation. Pull stations graeas may be omitted utal pull stations are within as stations. Pull stations are n of egress. Electronic or tests are available. A curce of power is provided. as are maintained in NFPA 72 and records of kept readily available. There ation of the fire alarm oved central station. Trvation and facility failed to and maintain 1 of 1 ams in accordance NFPA 72, 3–8.1 m system		STREET A	CARLISLE ST	litiy tio ntirol cluding here is fiected e: s nel is	(X5) COMPLETION DATE
	be located in a likely to be hea 1-5.4.4 require	es trouble signals to n area where it is ard. NFPA 72, es fire alarms, nals, and trouble			will assure tthatt tthere is an aralertt tto problems as well as the indicattor Other residents that have the potental to be affected have bounded by: Pottenttally all residentts could eftectted Please refter tto systi	een	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZDIX21

Facility ID: 000355

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLETED
		155688	B. WIN			08/01/2011
		<u> </u>	D. 1111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	t.		1	CARLISLE ST	
	NDVILLE COMMUN	NITY HOME		1	ANDVILLE, IN47535	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	•	DATE
	· · · · · · · · · · · · · · · · · · ·	nnunciated. This			implementted tto assure complian	ce
	deficient practi	ce could affect all			witth tthis ttag The measures or systematc	
	residents, staff	and visitors in the			changes that have been put into	
	existing portio	n of the facility.			place to ensure that the deficient	
					practce does not recur include :	
	Findings includ	le:			A ftre vendor will be insttalling	
	J				updattes tto tthe currentt ftre pan	el
	Based on obse	rvation on			The new systtem will allow ftor au	dio
		ng the alarm test at			alertts ftor any problems in tthe	
					systtem The ftacilitty sttaft will be	
	•	the Maintenance			in-serviced once tthis systtem is	
	Supervisor, the	-			insttalled The correctve acton taken to	
		Transmitter (DACT)			monitor perfiormance to assure	
	next to the fire	alarm control			compliance through quality	
	panel (FACP) at	the Nurses' Station			assurance is:	
	was placed in t	rouble from phone			The updatted ftre alarm systtem w	vill
	line failure (ph	one line #1). The			be monittored by tthe Mainttenan	ce
	DACT did illum	inate a vellow			Directtor as partt oft tthe preventt	ve
		however, there was			mainttenance program In additto	1,
	no local audio				tthe ftre vendor will also be involv	
		DACT. Based on			witth routtne ttesttng oft tthe syst	
	•				accordance witth tthe regulattonA	•
		3/01/11 at 1:35			identtfted issues will be immediate correctted The Administrattoror	.eiy
	-	tenance Supervisor			designee, will review tthe prevent	tve
	acknowledged				mainttenance documenttatton	
		ninate a trouble			quartterly ftor compliance	
	signal, but, did	l not initiate a local			The date the systemic changes wi	11
	audio trouble s	ignal, furthermore,			be completed:	
	at 1:45 p.m., tl	ne Maintenance			The ftacilitty respectfully requests	I
	Supervisor indi	cated the phone			waiver tto exttend tthe datte certt	
	=	received by the fire			The esttmatted time oft correcttor	ı is
	alarm monitori	•			December 31, 2011.	
		3 F/-				
	3.1-19(b)					
	J.1-19(D)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLE	
		155688	B. WIN	G		08/01/20)11
NAME OF 1	PROVIDER OR SUPPLIER	- {			ADDRESS, CITY, STATE, ZIP CODE		
	NDV /// . E 00141411	UT) (1 0 1 4 5		1	CARLISLE ST		
FREELA	NDVILLE COMMUN			FREEL	ANDVILLE, IN47535		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	177	TAG			DATE
	Based on obse		K	0051	K051		12/31/2011
	interview, the f	acility failed to			Iti is tihe practice off tihis ffaciliti assure tihati tihe ffre alarm conti	· I	
	properly test a	nd maintain 1 of 1			panel works appropriatiely include	1	
	fire alarm syste	ems in accordance			an audible tirouble signal iff tiher	·	
	with NFPA 72.	NFPA 72, 3-8.1			a problem witih tihe systiem		
	allows fire alar	m system			The correcton acton taken fior		
	components to	share control			those residents fiound to be afied	ted	
	equipment or o	operate as stand			by the deficient practce include :		
		but in any case,			There are no speciftc residentts identtfted. The ftre systtem panel	ic	
		rranged to function			going tto be updatted The updatte		
	as a single syst	•			will assure tthatt tthere is an audi		
	1 -	es trouble signals to			alertt tto problems as well as tthe	litt	
	· ·	n area where it is			indicattor		
					Other residents that have the		
	likely to be hea				potental to be afiected have been	1	
	1-5.4.4 require				identfied by :		
	1	ınals, and trouble			Pottenttally all residentts could be eftectted Please refter tto systtem		
	signals to be d				implementted tto assure complian		
		nnunciated. This			witth tthis ttag		
	· ·	ice could affect all			The measures or systematc		
	· ·	and visitors in the			changes that have been put into		
	existing portio	n of the facility.			place to ensure that the deficient		
					practce does not recur include :		
	Findings includ	le:			A ftre vendor will be insttalling updattes tto tthe currentt ftre par	nol .	
					The new systtem will allow ftor au		
	Based on obse	rvation on			alertts ftor any problems in tthe		
	08/01/11 duri	ng the alarm test at			systtem The ftacilitty sttaft will be		
	1:30 p.m. with	the Maintenance			in-serviced once tthis systtem is		
	Supervisor, the				insttalled		
	· ·	Transmitter (DACT)			The correctve acton taken to		
	next to the fire				monitor perfiormance to assure compliance through quality		
		t the Nurses' Station			assurance is:		
	l •	rouble from phone			The updatted ftre alarm systtem v	vill	
	I = =	one line #1). The			be monittored by tthe Mainttenar		
	I ille fallure (pri	one inte #1). The					

000355

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155688 08/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 310 W CARLISLE ST FREELANDVILLE COMMUNITY HOME FREELANDVILLE, IN47535 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Directtor as partt oft tthe preventive DACT did illuminate a yellow mainttenance program In additton, trouble signal, however, there was tthe ftre vendor will also be involved no local audio trouble signal witth routtne ttesttng oft tthe systtem in initiated by the DACT. Based on accordance witth tthe regulattonAny interview on 08/01/11 at 1:35 identtfted issues will be immediattely correctted The Administrattoror p.m., the Maintenance Supervisor designee, will review the preventive acknowledged the phone line mainttenance documenttatton failure did illuminate a trouble quartterly ftor compliance signal, but, did not initiate a local The date the systemic changes will audio trouble signal, furthermore, be completed: at 1:45 p.m., the Maintenance The ftacilitty respectfully requestts a waiver tto exttend tthe datte certtain Supervisor indicated the phone The esttmatted time oft correction is line failure was received by the fire December 31, 2011. alarm monitoring company. 3.1-19(b)If there is an automatic sprinkler system, it is K0056 installed in accordance with NFPA 13, SS=E Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25. Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 K0056 K056 12/31/2011 Based on observation and Iti is tihe practice off tihis ffacility tio interview, the facility failed to assure tihati tihe all necessary areas provide sprinkler coverage for 1 of are sprinkled properly in 2 areas outside and attached to accordance witih tihe regulation the building and constructed of The correcton acton taken fior

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Event ID:

ZDIX21

Facility ID: 000355

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155688	B. WIN	IG		08/01/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	KO VIDEK OK SOI I EIEK			310 W	CARLISLE ST	
FREELAI	NDVILLE COMMUN	IITY HOME		FREEL	ANDVILLE, IN47535	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	combustible ma	aterial. NFPA 13,			those residents fiound to be afiec	ted
	1999 Edition at	t 5–13.8.1 requires			by the deficient practce include :	
	sprinklers be ir	nstalled under			There are no speciftc residentts	
	combustible ex	cterior roofs			identtfted The side overhang nex tto tthe dining room will be sprink	
	exceeding four	feet in width. This			as partt oft updattes in tthe ftre sy	
	_	ce could affect any			Other residents that have the	Stem
	of the 35 reside	•			potental to be afiected have beer	,
					identfied by :	
		acility during time			Pottenttally all residentts could be	
	spent in the Di	-			eftectted Please refter tto systtem	is .
	needing to exit	through the two			implementted tto assure compliar	nce
	Dining Room e	xits to the outside.			witth tthis ttag	
					The measures or systematc	
	Findings includ	le:			changes that have been put into	
	_				place to ensure that the deficient practce does not recur include :	
	Based on obser	vation on			A ftre vendor will be insttalling	
		0:50 a.m. during a			updattes tto tthe currentt ftre syst	tem
	tour of the faci				including tthe additton oft sprinkle	
		•			tto areas tthatt require tthis	
		upervisor, the side			intterventton The ftacilitty sttaft w	ill be
	-	e Dining Room had			in-serviced once tthe sprinklers ar	e
	a thirty six foot	· ·			insttalled	
	overhang. This				The correctve acton taken to	
	constructed of	wood framing			monitor perfiormance to assure	
	above the meta	al covered overhang			compliance through quality	
	and was not pr	ovided with			assurance is: The updatted sprinkler systtem wi	II ha
	sprinkler cover				monittored by tthe Mainttenance	ii be
	•	he Maintenance			Directtor as partt oft tthe prevent	eve
	Supervisor at th				mainttenance program In additto	
	observation.	ic aime or			tthe ftre vendor will also be involv	·
	observation.				witth routtne ttesttng oft tthe syst	tem in
	2.1.10/5				accordance witth tthe regulattonA	ny
	3.1-19(b)				identtfted issues will be immediat	tely
					correctted The Administtrattoror	
					designee, will review the prevent	tve
					mainttenance documenttatton	
					L	

000355

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
		155688	B. WIN	G		08/01/2011	
NAME OF D	DOMDED OD CHINDLIED			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			310 W	CARLISLE ST		
FREELAI	NDVILLE COMMUN	IITY HOME		FREEL	ANDVILLE, IN47535		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET	TION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)	DATE	
					quartterly ftor compliance		
					The date the systemic changes wi	"	
					be completed:		
					The ftacilitty respectfully requests:		
					waiver tto exttend tthe datte certt		
					The esttmatted time oft correcttor	I IS	
170063	Doguired automati	a apripklar avatama ara	ł		December 31, 2011.	•	
K0062 SS=F		c sprinkler systems are tained in reliable operating					
33 - F	•	inspected and tested					
		7.6, 4.6.12, NFPA 13, NFPA					
	25, 9.7.5	, ,					
	1. Based on ob	servation and	K(0062	К062	08/31/2	2011
	interview, the fa				Iti is tihe practice off Freelandville	!	
	ensure 8 of ove	•			Communitiy Home tio assure tiha	ti all	
		•			sprinklers are maintiained		
		cility were free of			appropriatiely and tihati and tiha	i l	
	paint. NFPA 10				tihere is a spare sprinkler head ffo		
	refers to NFPA	25, Standard for			tihe tiypes off sprinklers utilized i	۱	
	the Inspection,	Testing, and			tihe ffacility		
	Maintenance of	Water-Based Fire			The correcton acton taken fior	. ,	
	Protection Syste	ems. NFPA 25			those residents flound to be affect	rea	
		s sprinklers to be			by the deficient practce include: There are no speciftc residentts		
	=	any sprinkler shall			identtfted The sprinkler heads		
					identified as having paintt on the	m in	
		it is painted. This			tthe 2567have been replaced. In		
	•	ce could affect any			additton, spare sprinkler heads ha	ve	
	of the 35 reside				been purchased tthatt are oft tthe		
	staff and visitor	rs while in the			ttype tthatt is uttlized in tthe build	ing tto	
	Dining Room or	r kitchen.			assure tthatt tthere ane oft each tty	pe	
					oft needed.		
	Findings includ	e:			Other residents that have the		
					potental to be afiected have been		
	Pacad on abase	vations on			identfied by :		
	Based on obser				Pottenttally all residentts could be		
	, ,	een 11:00 a.m. and			eftectted Please refter tto systtem		
	11:20 a.m. duri	ing a tour of the			implementted tto assure compliar	ce	
	facility with the	Maintenance			witth tthis ttag		
					The measures or systematc	ı	

000355

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	01	COMPLET	TED
		155688	B. WIN			08/01/20	11
		<u> </u>	D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CARLISLE ST		
	NDVILLE COMMUN	NITY HOME		1	ANDVILLE, IN47535		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE '	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	·		DATE
	Supervisor, the	following areas			changes that have been put into		
	had sprinkler h	neads partially			place to ensure that the deficient practce does not recur include :		
	covered with p	aint: six of fifteen			The preventtve mainttenance plan	,	
	sprinkler head:	s in the Dining			has been updatted tto assure ttha	I .	
	Room and two	of four sprinkler			sprinkler heads are reviewed and	I .	
		tchen. This was			in good operattng conditton. In		
		by the Maintenance			additton, sprinkler spare inventtor	у	
	_	he time of each			has also been added tto tthe		
	observation.	ine diffic of cacif			preventtve mainttenance plan tto		
	observation.				assure tthatt tthere is a minimum	· ·	
					spare sprinkler heads ftor each tty	pe	
	3.1-19(b)				uttlized in tthe building The mainttenance supervisor has beer		
					in-serviced relatted tto tthe review	I	
	2. Based on ol	oservation and			sprinkler heads on a quartterly ba		
	interview, the f	facility failed to			as partt oft tthe preventive	515	
	ensure 1 of 1 a	automatic sprinkler			mainttenance plan		
	head storage c	abinets was			The correctve acton taken to		
	provided with a	at least two of each			monitor perfiormance to assure		
	_ ·	er head used in the			compliance through quality		
	1	25, 2–4.1.4 requires			assurance is:		
	_ ·	two sprinklers of			The sprinkler heads will be		
		· · · · · · · · · · · · · · · · · · ·			monittored by tthe Mainttenance	I .	
	1 ''	temperature rating			Directtor as partt oft tthe preventt mainttenance program on a quart	I	
	installed shall				basis. Any identtfted issues will b	· 1	
	cabinet on the				immediattely correctted The	~	
	replacement pi	•			Administtrattgror designee, will		
	deficient practi	ice could affect all			review tthe preventtve mainttena	nce	
	residents, as w	ell as staff and			documenttatton quartterly ftor		
	visitors in the f	facility.			compliance.		
					The date the systemic changes wi	iii	
	Findings includ	de:			be completed:		
		-			Augustt31, 2011		
	Based on obse	rvation on					
	08/01/11 at 1	1:19 a.m. during a					
	tour of the faci	lity with the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155688		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2011		
	PROVIDER OR SUPPLIER		STRE 310	ET ADDRESS, CITY, STATE, ZIP CODE W CARLISLE ST ELANDVILLE, IN47535	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0069 SS=B	sprinkler head spare sprinkler included one si head and one particular sprinkler heads sprinkler heads acknowledged Supervisor at the observation, fur Maintenance Suthere were no opendent type sheads in the factory and observation to ensure 1 of systems was classed on record and observation to ensure 1 of systems was classed on standard Control and Fir Commercial Control and Fir Control and Fir Commercial Control and Fir C	The remaining were upright type This was by the Maintenance ne time of rthermore, the upervisor indicated other side wall or pare sprinkler cility. are protected in accordance 2.6, NFPA 96 d review, interview n; the facility failed I kitchen exhaust eaned at least NFPA 96, 1998 rd for Ventilation e Protection of oking Operations, hoods, grease s, fans, ducts, and ances shall be e metal at frequent	K0069	K069 Iti is tihe practice off Freelandvill Communitiy Home tio assure tih tihe kitichen exhausti systiem is cleaned semiannually. The correcton acton taken fior those residents fiound to be afie by the deficient practce include: There are no speciftc residentts identifted. The exhausti systiem been tthoroughly cleaned Other residents that have the potental to be afiected have bee identfied by: Pottenttally all residentts could be eftectted Please refter tto systien	ati cted has

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZDIX21

Facility ID: 000355

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	01	COMPLETED
		155688	B. WIN			08/01/2011
					ADDRESS, CITY, STATE, ZIP CODE	ļ.
NAME OF	PROVIDER OR SUPPLIEF	{		310 W (CARLISLE ST	
	NDVILLE COMMUN	NITY HOME		FREEL	ANDVILLE, IN47535	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	•	LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	_	vily contaminated			implementted tto assure compliar witth tthis ttag	ice
	with grease or	oily sludge. After			The measures or systematc	
	the exhaust sy	stem is cleaned to			changes that have been put into	
	bare metal, it s	shall not be coated			place to ensure that the deficient	
	with powder or	other substance.			practce does not recur include :	
	The entire exh	aust system shall be			The preventtve mainttenance plar	
	inspected by a	properly trained,			has been updatted tto assure ttha	
		certified company			kittchen exhaustt systtem is cleane	
	l •	accordance with			semiannually in accordance witth	tthe
		able 8-3.1 requires			regulatton. The mainttenance supervisor has been in-serviced	
		g moderate volume			relatted tto semiannual cleaning o	_{ft}
	cooking operat				tthe exhaustt systtem	
					The correctve acton taken to	
	· ·	iannually. This			monitor perfiormance to assure	
	1	ice could affect any			compliance through quality	
		or visitor in the			assurance is:	
	vicinity of the l	citchen.			The kittchen exhaustt systtem will	be
					monittored by tthe Mainttenance	140
	Findings includ	le:			Directtor as partt oft tthe preventt mainttenance program on a quart	
					basis. Any identtfted issues will b	•
	Based on review	w of the kitchen			immediattely correctted The	
	range inspection	on reports in the			Administtrattgror designee, will	
	Fire Alarm Info	rmation book on			review tthe preventtve mainttena	nce
	08/01/11 at 10	0:00 a.m. with the			documenttatton quartterly ftor	
		upervisor present,			compliance.	.,,
		ocumentation to			The date the systemic changes wi be completed:	"
		en range hood had			Augustt31, 2011	
		vithin the past six				
		d on observation at				
		ing a tour of the				
	facility with the					
	I -	re was a sticker on				
		ige hood which				
	indicated the ra	ange hood was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155688			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 08/01/20	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST FREELANDVILLE, IN47535					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
K0143 SS=E	the next schedin October of 2 confirmed by the Supervisor at the observation. 3.1–19(b) Transferring of oxy (a) separated from wherein patients at treated by a separt 1-hour fire-resistive (b) in an area that sprinklered, and has flooring; and (c) in an area post transferring is occur the immediate area accordance with N Compressed Gas Based on observinterview, the frensure the door storage rooms transferring take provided with a device. This decould affect 13	rgen is: any portion of a facility re housed, examined, or ation of a fire barrier of e construction; is mechanically ventilated, as ceramic or concrete ed with signs indicating that turring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 vation and acility failed to r to 1 of 1 oxygen where oxygen tes place was a self closing eficient practice residents, as well itors in the A hall.	K	0143	K143 Iti is tihe practice off Freelandville Communitiy Home tio assure tiha doors tio tihe oxygen room have selffelosures The correcton acton taken fior those residents fiound to be afiect by the deficient practce include: There are no speciftc residentts identtfted. The oxygen room has have selftelosure devices insttalled Other residents that have the potental to be afiected have been identified by:	ti t ed	08/31/2011	

l i		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLETED
		155688	B. WIN			08/01/2011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			310 W	CARLISLE ST	
FREELA	NDVILLE COMMUN	IITY HOME		1	ANDVILLE, IN47535	
(X4) ID	STIMMADV S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
		,	-		Pottenttally all residentts could be	
					eftectted Please see systtemattc	
	Based on obser				changes below tto assure correctt	on
	08/01/11 at 12	2:20 p.m. during a			The measures or systematc	J
	tour of the faci	lity with the			changes that have been put into	
	Maintenance Su	pervisor, the			place to ensure that the deficient	
		transfer room was			practce does not recur include :	
		ith a self closing			The oxygen door has been placed	on
					tthe preventtve mainttenance pla	n
		as acknowledged by			This will assure tthatt tthe se l6 tckir	ng
		e Supervisor at the			closure tthatt was insttalled is wor	king
	time of observa	ition, furthermore,			properly as partt oft tthe preventt	ve
	the Maintenanc	e Supervisor			mainttenance plan on a quartterly	'
	indicated oxyge	en transferring			basis The mainttenance Directtor	has
	takes place in t	he oxygen			been in- serviced relatted tto tthe	
	storage/transfe	· -			ftollowing oft tthe preventtve	
					mainttenance plan	
	2.1.10/b)				The correctve acton taken to	
	3.1-19(b)				monitor perfiormance to assure compliance through quality	
					assurance is:	
					The preventive maintitenance plan	ns
					will be reviewed att tthe quartterly	
					meettngs. The Mainttenance	,
					Directtor or designee, will be	
					responsible ftor assuring tthatt tth	e
					selftɛlosing door tto tthe oxygen re	oom
					is operattng properly. Any identtfi	ted
					issues will be immediattely	
					correctted The Administtrattgror	
					designee, will review tthe prevent	tve
					mainttenance documenttatton	
					quartterly ftor compliance	
					The date the systemic changes wi	
, l					be completed:	
120144	Generators are ins	spected weekly and			Augustt31, 2011	
K0144 SS=F		ad for 30 minutes per				
55-1	month in accordan	•				
	3.4.4.1.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE (CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPI	
		155688	B. WIN	G		08/01/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
WHILE OF I	ROVIDER OR SOLVER			I	W CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME		FREE	ELANDVILLE, IN47535		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. Based on o	bservation and	K()144	K144		12/31/2011
	interview, the f	acility failed to			Iti is tihe practice off Freelandvil		
	ensure 2 of 2 e	emergency			Communitiy Home tio assure tih	ati	
	generators wer	e provided with an			tihe generatior is checked in accordance witih tihe regulation		
	1 ~	ator in a location			guidelines and has alarm	y	
	readily observe				annunciatior ati a regular work		
	personnel at a				stiation is equipped witih a remo	otie	
	1 '	a nurses' stations.			manual stiop and tio assure tiha	ti any	
					off-sitie ffuel utilized is ffrom a		
	•	h Care Facilities,			reliable source.		
	3–4.1.1.15 req				The correcton acton taken fior		
	annunciator, st	orage battery			those residents fiound to be afie		
	powered, shall	be provided to			by the deficient practce include	;	
	operate outsid	e of the generating			There are no speciftc residentts identtfted Please see under syst	toms	
	room in a locat	tion readily			implementted tto assure complia		
	observed by or	perating personnel			witth tthis ttag	nice .	
		ork station. The					
	_	all indicate alarm			Other residents that have the		
		he emergency or			potental to be afiected have bee	n	
		r source as follows:			identfied by :		
					Pottenttally all residentts could b		
		isual signals shall			eftectted Please refter tto systter		
	indicate:				implementted tto assure complia witth tthis ttag	псе	
	1. When the en	-			The measures or systematc		
	auxiliary powe				changes that have been put into	ı	
	_	apply power to load.			place to ensure that the deficien		
	2. When the ba	ittery charger is			practce does not recur include :		
	malfunctioning	J.			A remotte alarm annunciattor fto	r	
	(b) Individual v	isual signals plus a			each generattor will be insttalled	in a	
	common audib	le signal to warn of			locatton readily observed by		
	an engine-gen	erator alarm			operating personnel att tithe nurs		
	condition shall				sttatton All sttaft will be inservice on the alarm annunciattor once		
		ing oil pressure.			been insttalled	111 1103	
	2. Low water to	- ·			A remotte shutt oft swittch ftor to	the	
		•			generattor will be insttalled in	-	
	5. Excessive Wa	ater temperature.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	01	COMPLI	ETED
		155688	B. WIN			08/01/20	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIEF	₹			CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME		1	ANDVILLE, IN47535		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	4. Low fuel – w	hen the main fuel			accordance witth tthe regulatton		
	storage tank co	ontains less than a			sttaft will be inserviced on tthe ne insttallatton oft tthe remotte shut		
	3-hour operati	ing supply.			swittch tto assure tthatt all sttaft v		
	5. Overcrank (failed to start).				have knowledge oft how tto remo		
	6. Overspeed.				sttop tthe generattor ift necessary	· · · · · · · · · · · · · · · · · · ·	
	· ·	ır work station will			A letter has been received ftrom t	the	
		periodically, an			oft-sitte gas company tthatt provid	des	
		sual derangement			ftuel ftor tthe smaller generattor a	as	
		riately labeled, shall			evidence oft reliabilitty oft tthe na	ıttural	
		•			gas supplier		
		at a continuously			The correctve acton taken to		
	monitored loca				monitor perfiormance to assure compliance through quality		
	1	ignal shall activate			assurance is:		
	when any of th	e conditions in			The newly insttalled alarm		
	3-4.1.1.15(a) a	and (b) occur but			annunciattor and remotte shutt of	ft	
	need not displa	ay these conditions			systtem will be monittored as part	tt oft	
	individually. T	his deficient			tthe preventtve mainttenance pla	n on	
	practice could	affect all residents,			a quartterly basis The Mainttenar	nce	
	as well as visite	ors and staff in the			Directtor or designee, will be		
	existina portio	n of the facility.			responsible ftor assuring tthatt tth	ne	
		,			newly insttalled annunciattor and		
	Findings includ	1a·			remotte shutt oft ftor tthe general routtnely checked and operattonal		
	i indings includ				In additton, preventtve mainttena	- 1	
	Dagad are also				will also include assuring tthatt a		
	Based on obse				letter oft reliabilitty is in place ftro	om	
		veen 10:45 a.m. and			tthe outtside vendor tthatt provid	es tthe	
	l '	ng a tour of the			ftuel ftor tthe generattoAny		
	facility with the	e Maintenance			identtfted issues will be immediat	tely	
	Supervisor, a r	emote alarm			correctted The Administtrattoror	.	
	annunciator fo	r the each generator			designee, will review the prevent	tve	
	was not provid	ed in a location			mainttenance documenttatton quartterly ftor compliance		
	I	ed by operating			The date the systemic changes w	_{iII}	
	personnel at a				be completed:	<i>"</i>	
	I -	a nurses' stations			The ftacilitty respectfully requestt	s a	
		ea in the facility.			waiver tto exttend tthe datte certt	- 1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155688		A. BUI	LDING	ONSTRUCTION 01	(X3) DATE S COMPL 08/01/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00/0 //-	
NAME OF I	PROVIDER OR SUPPLIEI	2			CARLISLE ST		
	NDVILLE COMMUI			1	ANDVILLE, IN47535		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	During an inte	rview on 08/01/11			The esttmatted ttme oft correctto	n is	
	1	he Maintenance			December 31, 2011.		
	•	nowledged there					
	were no remot						
	annunciators f	or each emergency					
	generator at th	e nurses' station or					
	any other area	in the facility.					
	3.1-19(b)						
	2. Based on ol	oservation and					
		facility failed to					
	ensure 1 of 2 e	· ·					
	1 ~	equipped with a					
		l stop. LSC 7.9.2.3					
	1	gency generators					
	1	er to emergency					
	1	ns shall be installed,					
	tested and mai						
	accordance wit						
	Standard for E	- ·					
	· ·	Systems. NFPA					
	110, 1999 edit						
	· ·	II installations shall					
		manual stop station					
	1 ''	ar to a break-glass elsewhere on the					
	I *	e the prime mover					
	NFPA 37, Stand	ide the building.					
		d Use of Stationary					
	Combustion Er	·					
		igines and Gas 3 Edition, at 8–2.2(c)					
	ruibilies, 1990	5 Luition, at 6-2.2(C)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	ETED
		155688	B. WIN	G		08/01/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME		FREEL/	ANDVILLE, IN47535		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!)		DATE
	requires engin						
	horsepower or						
		hutting down the					
	_	ngine and from a					
		n. This deficient					
	_ =	affect all occupants					
	in the facility.						
	Findings includ	le:					
	Based on obse						
	· ·	veen 10:45 a.m. and					
		ng a tour of the					
	facility with the						
	-	idence of a remote					
	shut off device	was not found for					
	the generator.	Based on interview					
	at 12:00 p.m. o	on 08/01/11, the					
	Maintenance Si	upervisor indicated					
	the large gene	rator was over 100					
	horsepower an	d was installed after					
	2003, and furt	her indicated there					
	was no remote	shut off device for					
	the generator.						
	3.1-19(b)						
	3. Based on ol	oservation and					
	interview, the f	acility failed to					
		site fuel source for					
	1 of 2 emerger	ncy generators was					
	_	source. NFPA 110,					
	1999 Edition, S						
	, -						

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	01	COMPI	LETED	
		155688	B. WIN	_		08/01/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
FREELA	NDVILLE COMMUI	NITY HOME		1	CARLISLE ST ANDVILLE, IN47535		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DETCIENCT)		DATE
		d Standby Power					
		ter 3, Emergency					
		EPS), 3–1.1, Energy					
	Sources states	-					
		s shall be permitted					
		emergency power					
	supply (EPS):	danna maada da ee ee					
	· ·	oleum products at					
	atmospheric p						
	· · · · · · · · · · · · · · · · · · ·	etroleum gas (liquid					
	or vapor withd						
	c) Natural or s	·					
	Exception: For						
		locations where the					
	l -	nterruption of off					
		es is high (e.g., due					
	· ·	flood damage or					
		utility unreliability),					
	Ī	of an alternate					
		sufficient to allow					
	full output of t	· ·					
	•	system (EPSS) to be					
		ne class specified					
	I	ed, with provision ransfer from the					
	primary energy						
	· ·	gy source. CMS					
	l -	nce of reliability of					
	the natural fue						
	contain all of t						
		t of reasonable					
	reliability of th	e natural gas					
	delivery;						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :		
ANDILAN	or connection	155688		LDING	01	08/01/2	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CARLISLE ST		
FREELA	NDVILLE COMMUN	IITY HOME		FREEL/	ANDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	b. A brief desc						D.M.E
		atement regarding					
	the						
	reliability;						
	c. A statement	there is a low					
	probability of i	nterruption of the					
	natural						
	gas;						
	d. A brief desc	ription that					
	l	atement regarding					
	the low						
	· ·	of interruption;					
	e. The signatu						
	⁻	the natural gas					
	vendor.	and a second of the contract of					
	·	oractice could affect					
	ali residents, st	aff and visitors.					
	Findings includ	e:					
ı	Based on obser	vation on					
	08/01/11 at 11	1:25 a.m. during a					
	tour of the faci	•					
	Maintenance Su	ipervisor, the small					
	emergency gen						
	basement was						
	natural gas onl						
	_	by the Maintenance					
	Supervisor at th						
		uring an interview					
	· ·	e Administrator					
		acility did not have					
	a letter from th	eir naturai gas					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPI	LETED
		155688	B. WIN			08/01/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R		1	CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME		FREELANDVILLE, IN47535			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second se	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	provider as evi	dence of reliability					
	of their natural	gas supply.					
	3.1-19(b)						
	3.1 13(b)						
K0000							i
120000							
	A Life Safety Co	ode Recertification	l K(0000	By submitting the enclosed		İ
	•	isure Survey was			material we are not admitting		
		·			truth or accuracy of any spe	cific	
	•	he Indiana State			findings or allegations. We		
	Department of				reserve the right to contest t		
	accordance wit	h 42 CFR 483.70(a).			findings or allegations as pa any proceedings and submit		
					these responses pursuant to		
	Survey Date: 0	8/01/11			regulatory obligations. The		
	•				requests that the plan of	,	
	Facility Numbe	r: 000355			correction be considered ou	r	
	Provider Numb				allegation of compliance to t		
					Life Safety Code Recertifica		
	AIM Number:	100273640			Survey conducted on Augus	t 1,	
					2011.		
	Surveyor: Lex	Brashear, Life Safety					
	Code Specialist	İ.					
	At this Life Safe	ety Code survey,					
		ommunity Home					
		in compliance with					
		•					
	•	for Participation in					
	Medicare/Medi						
	Subpart 483.70	•					
	from Fire and t	he 2000 edition of					
	the National Fi	re Protection					
	Association (NF	FPA) 101, Life Safety					
		1 410 IAC 16.2. The					
	code (LSC) and	Total Tile					
							1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155688		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/01/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST FREELANDVILLE, IN47535					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Ambulance Bay	Chapter 18, New						
	construction ar sprinklered. The connected to the alarm system we detectors in the The facility has	be of Type V (111) nd was not nis addition is ne facility's fire						
	The facility was compliance wit aforementioned requirements a following:	h the						
K0050 SS=C	varying conditions shift. The staff is the staff is the staff is the staff is the staff. The staff is the staff is the staff is the staff is the staff is aware that drills routine. Responsi conducting drills is competent person exercise leadership conducted between announcement manaudible alarms.	s who are qualified to p. Where drills are n 9 PM and 6 AM a coded ay be used instead of 18.7.1.2						
	Based on recordinterview, the f		K0050	K050 Iti is tihe practice off tihis ffaciliti assure tihati ffre drills are condu	•			

000355

STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	02	COMPL	ETED
		155688	A. BUI B. WIN			08/01/2	011
		<u> </u>	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			CARLISLE ST		
EDEE! V	NDVILLE COMMUI	NITY HOME		1	ANDVILLE, IN47535		
		NIT TIONE		INCLL	ANDVILLE, IN47333		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	ensure fire dril	lls were held at			ati leasti quartierly on each shiff		
	varied times fo	or 1 of 3 employee			The correcton acton taken fior		
	shifts during 4	of 4 quarters. This			those residents flound to be afie		
	deficient practice could affect all				by the deficient practce include : There are no speciftc residentts		
	· ·	e in the Ambulance			identtfted Please see under systi	ams	
	Bay portion of				implementted tto assure complia		
	Bay portion of	the facility.			witth tthis ttag	1100	
					Other residents that have the		
	Findings includ	de:			potental to be afiected have bee	n	
					identfied by :		
	Based on revie	w of the facility's			Pottenttally all residentts could b	е	
	fire drills in the	e Fire Alarm			eftectted Please refter tto systter	ns	
	Information bo	ook on 08/01/11 at			implementted tto assure complia	nce	
	9:15 a.m. with	the Maintenance			witth tthis ttag		
		sent, four of four,			The measures or systematc		
	l '	re drills since July of			changes that have been put into		
		· · · · · · · · · · · · · · · · · · ·			place to ensure that the deficien	t	
	· ·	formed between the			practce does not recur include : A ftre drill has been conductted f		
	l	p.m. and 3:05 p.m.			each shift per quartter in2011. The		
	During an inte	rview at the time of			ftre drills are scheduled per tthe	ic	
	record review,	the Maintenance			preventtve mainttenance schedu	le tto	
	Supervisor ack	nowledged the			be held each shift quartterly. The		
	times of all fou	ur second shift fire			Mainttenance Directtor has been		
	drills.				serviced relatted tto tthe sttagger	ing oft	
	411113.				ttmes witthin tthe required shifts	tto	
	2 1 10/b)				inittatte tthe ftre drills		
	3-1.19(b)				The correctve acton taken to		
					monitor perfiormance to assure		
					compliance through quality		
					assurance is:		
					The ftre drills will be monittored		
					partt oft tthe preventive maintte	nance	
					review att tthe quartterly QA		
					meettngs. The Mainttenance Directtor or designee, will be		
					responsible ftor assuring tthatt tt	he ftre	
					drills are completted in accordant		
					a. ms are completted in accordant		

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I		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CON	STRUCTION	(X3) DATE S COMPL	
AND TEAN	or connection	155688	A. BUILD	ING	02	08/01/2	
			B. WING	STREET AL	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARLISLE ST		
FREELA	NDVILLE COMMUN	IITY HOME			NDVILLE, IN47535		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
K0051 SS=F	A fire alarm system components, device according to NFPA warning of fire in a Activation of the coby manual fire alard detection, or exting Pull stations are local Electronic or writte available. A reliablis provided. Fire a maintained in acconstitutional Fire Alarm maintenance are kis remote annuncia system to an appropriate and appropriate alarm system to an appropriate alarm system to an appropriate alarm system to an appropriate alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system to alarm system systems, allows fire alarm components to equipment or coalone systems,	ces or equipment is installed a 72, to provide effective my part of the building. It is implete fire alarm system is imminitiation, automatic guishing system operation. It is cated in the path of egress. It is records of tests are lesseond source of power alarm systems are ordance with NFPA 72, in Code, and records of teept readily available. There ation of the fire alarm oved central station. Vation and accility failed to indiminitain 1 of 1 is in accordance NFPA 72, 3–8.1 in system share control operate as stand but in any case, tranged to function	K00	TAG	witth the schedule and thatt shift appropriattely sttaggered Any identified issues will be immediate corrected. The Administrattor designee, will review the prevent maintenance documentation quarterly for compliance. The date the systemic changes will be completed: Augustt31, 2011 K051 Iti is tihe practice off tihis ffacilitiy assure tihati tihe ffre alarm contin panel works appropriatiely includian audible tirouble signal iff tihere a problem with tihe system. The correcton acton taken fior those residents flound to be affect by the deficient practice include: There are no specific residents identified. The ftre system panel is going to be updatted. The updatte will assure that tithere is an audio will assure that tithere is an audio.	es are ely eve find oil ing e is eed	DATE 12/31/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZDIX21

Facility ID:

000355 If continuation sheet

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li '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	02	COMPLE		
	155688		B. WIN	iG		08/01/20)11
NAME OF	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	CARLISLE ST		
FREELA	NDVILLE COMMUN	NITY HOME		FREEL	ANDVILLE, IN47535		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1-5.4.6 require	es trouble signals to			alertt tto problems as well as tthe	litt	
	be located in a	n area where it is			indicattor		
	likely to be hea	ard. NFPA 72,			Other residents that have the potental to be afiected have been	.	
	1-5.4.4 require	es fire alarms,			identfied by :	'	
	supervisory sig	ınals, and trouble			Pottenttally all residentts could be		
	signals to be d				eftectted Please refter tto systtem	1	
	_	nnunciated. This			implementted tto assure compliar	nce	
	1	ice could affect any			witth tthis ttag		
	· ·	dents, staff and			The measures or systematc		
		n the Ambulance			changes that have been put into		
					place to ensure that the deficient		
	Bay portion of	the facility.			practce does not recur include: A ftre vendor will be insttalling		
		_			updattes tto tthe currentt ftre pan	el	
	Findings includ	le:			The new systtem will allow ftor au	1	
					alertts ftor any problems in tthe		
	Based on obse	rvation on			systtem The ftacilitty sttaft will be		
	08/01/11 duri	ng the alarm test at			in-serviced once tthis systtem is		
	1:30 p.m. with	the Maintenance			insttalled		
	Supervisor, the	Digital Alarm			The correctve acton taken to		
	Communicator	Transmitter (DACT)			monitor perfiormance to assure compliance through quality		
	next to the fire	alarm control			assurance is:		
	panel (FACP) at	t the Nurses' Station			The updatted ftre alarm systtem w	/ill	
	_ ·	rouble from phone			be monittored by tthe Mainttenan	1	
		one line #1). The			Directtor as partt oft tthe preventt	:ve	
	DACT did illum				mainttenance program In additto	n,	
		however, there was			tthe ftre vendor will also be involv		
	_				witth routine ttesting oft tithe syst	1	
	no local audio				accordance witth tthe regulatton A identified issues will be immediat	· 1	
	· ·	DACT. Based on			correctted The Administrattoror	cciy	
		3/01/11 at 1:35			designee, will review the prevent	tve	
	_ ·	enance Supervisor			mainttenance documenttatton		
	acknowledged	•			quartterly ftor compliance		
	failure did illun	ninate a trouble			The date the systemic changes wi	:II	
	signal, but, did	l not initiate a local			be completed:		
	audio trouble s	signal, furthermore,			The ftacilitty respectfully requests:	s a	

000355

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 02	(X3) DATE S COMPL 08/01/20	ETED
NAME OF PROVIDER OR SUPPLIER FREELANDVILLE COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 310 W CARLISLE ST FREELANDVILLE, IN47535				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Έ	(X5) COMPLETION DATE
W0057	line failure was alarm monitori 3.1-19(b)	cated the phone received by the fire ng company.			waiver tto exttend tthe datte certta. The esttmatted ttme oft correcttor December 31, 2011.		
K0056 SS=E	installed in accord Standard for the Ir Systems, with app devices, and equip coverage of all pol system is maintain NFPA 25, Standar and Maintenance Protection System adequate water su system is equippe switches which are	atic sprinkler system, ance with NFPA 13, astallation of Sprinkler roved components, benent, to provide complete rtions of the facility. The aed in accordance with d for the Inspection, Testing, of Water-Based Fire s. There is a reliable, apply for the system. The d with waterflow and tamper e connected to the fire 18.3.5.					
	Based on obserinterview, the fiprovide an autosystem which proverage in 1 ocompartments of the facility. practice could a of residents, as	acility failed to comatic sprinkler crovided complete of 1 smoke in the new portion This deficient affect any number is well as staff and in the Ambulance	K0	056	Iti is tihe practice off tihis ffacilitiy assure tihati tihe all necessary are are sprinkled properly in accordance witih tihe regulation. The correcton acton taken fior those residents fiound to be affect by the deficient practice include: There are no specific residentts identified. The side overhang next to tithe dining room will be sprinkl as part oft updattes in tithe fire sy Other residents that have the potental to be affected have been identified by: Pottenttally all residents could be effectted Please refter tto systtem	e as t ed t t led sttem	12/31/2011
	Based on obser	vation on			implementted tto assure complian		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688		(X2) MULTIPLE CC A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 08/01/2011	
	PROVIDER OR SUPPLIER		310 W	ADDRESS, CITY, STATE, ZIP CODE CARLISLE ST ANDVILLE, IN47535	-1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
K0144 SS=F	tour of the faci Maintenance St Ambulance Bay the existing po by a sprinklere however, the A not provided w sprinkler cover acknowledged Supervisor at the observation, fur Maintenance St the facility uses Bay for transport and from the fact 3.1–19(b)	spected weekly and and for 30 minutes per		witth tthis ttag The measures or systemate changes that have been put interplace to ensure that the deficiency practice does not recur include: A ftre vendor will be insttalling updattes to the currentt ftre sy including the additton oft sprint to areas tthatt require tthis intervention. The ftacility sttaft in-serviced once tthe sprinklers insttalled The corrective acton taken to monitor performance to assure compliance through quality assurance is: The updatted sprinkler system is monittored by tthe Mainttenance Directtor as partt off tthe prevent mainttenance program. In addition, the fire vendor will also be involved in the fire vendor will also be involved in the fire vendor will be immedically corrected. The Administrattors designee, will review the prevent mainttenance documentation quartterly ftor compliance. The date the systemic changes be completed: The ftacilitty respectfully request waiver tto extlend the datte certain the datte certain the datte certain the datte certain the stimulated time off correction.	ysttem iklers will be are will be ce nttve tton, blved ysttem in unAny iattely or enttve will stts a crttain
	3.4.4.1. 1. Based on o	bservation and	K0144	K144 Iti is tihe practice off Freelandv	12/31/2011

000355

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155688			ULTIPLE CO LDING	NSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/01/2011	
133000			B. WIN			00/01/2011
NAME OF 1	PROVIDER OR SUPPLIEF	t			DDRESS, CITY, STATE, ZIP CODE	
		HTV HOME		1	CARLISLE ST	
	NDVILLE COMMUN	-		FREELA	ANDVILLE, IN47535	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	interview, the f	-			Communitiy Home tio assure tiha	π
	ensure 2 of 2 e	- ·			tihe generatior is checked in accordance witih tihe regulatiory	
	generators wer	e provided with an			guidelines and has alarm	
	alarm annuncia	ator in a location			annunciatior ati a regular work	
	readily observe	ed by operating			stiation is equipped witih a remo	tie
	personnel at a	regular work			manual stiop and tio assure tihat	any
	_ ·	a nurses' stations.			off-sitie ffuel utilized is ffrom a	
		h Care Facilities,			reliable source.	
	3-4.1.1.15 req				The correcton acton taken fior	
	annunciator, st				those residents fiound to be afiec	ted
		•			by the deficient practice include :	
	l '	be provided to			There are no speciftc residentts identtfted Please see under systte	ame
	l -	e of the generating			implementted tto assure compliar	
	room in a locat	•			witth tthis ttag	
	observed by op	perating personnel			J	
	at a regular wo	rk station. The			Other residents that have the	
	annunciator sh	all indicate alarm			potental to be afiected have been	,
	conditions of t	he emergency or			identfied by :	
	auxiliary powe	r source as follows:			Pottenttally all residentts could be	
		isual signals shall			eftectted Please refter tto systtem	
	indicate:				implementted tto assure compliar	ice
	1. When the en	nergency or			witth tthis ttag The measures or systematc	
	auxiliary power	- ·			changes that have been put into	
	1 ' '				place to ensure that the deficient	
		ipply power to load.			practce does not recur include :	
		ittery charger is			A remotte alarm annunciattor ftor	
	malfunctioning				each generattor will be insttalled i	n a
		isual signals plus a			locatton readily observed by	
	common audib	le signal to warn of			operattng personnel att tthe nurse	
	an engine-gen	erator alarm			sttatton All sttaft will be inserviced on tthe alarm annunciattor once it	
	condition shall	indicate:			been insttalled	ı iidə
	1. Low lubricat	ing oil pressure.			A remotte shutt oft swittch ftor tth	ne
	2. Low water te	emperature.			generattor will be insttalled in	
		•			accordance witth tthe regulattonA	.11
	3. Excessive water temperature.4. Low fuel – when the main fuel				sttaft will be inserviced on tthe ne	w

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 02 A. BUILDING 155688 08/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 310 W CARLISLE ST FREELANDVILLE COMMUNITY HOME FREELANDVILLE, IN47535 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE insttallatton oft tthe remotte shutt oft storage tank contains less than a swittch tto assure tthatt all sttaft would 3-hour operating supply. have knowledge oft how tto remottely 5. Overcrank (failed to start). sttop tthe generattor ift necessary 6. Overspeed. A letter has been received ftrom tthe Where a regular work station will oft-sitte gas company tthatt provides be unattended periodically, an ftuel ftor tthe smaller generattor as evidence oft reliabilitty oft tthe nattural audible and visual derangement gas supplier signal, appropriately labeled, shall The correctve acton taken to be established at a continuously monitor perfiormance to assure monitored location. This compliance through quality derangement signal shall activate assurance is: The newly insttalled alarm when any of the conditions in annunciattor and remotte shutt oft 3-4.1.1.15(a) and (b) occur but systtem will be monittored as partt oft need not display these conditions tthe preventtve mainttenance plan on individually. This deficient a quartterly basis The Mainttenance practice could affect all residents. Directtor or designee, will be responsible ftor assuring tthatt tthe as well as visitors and staff while newly insttalled annunciattor and in the Ambulance Bay portion of remotte shutt oft ftor tthe generattor is the facility. routtnely checked and operattonal In additton, preventive mainttenance Findings include: will also include assuring tthatt a letter oft reliabilitty is in place ftrom tthe outtside vendor tthatt provides tthe Based on observations on ftuel ftor tthe generatto Any 08/01/11 between 10:45 a.m. and identtfted issues will be immediattely 1:30 p.m. during a tour of the correctted The Administtrattoror facility with the Maintenance designee, will review tthe preventtve mainttenance documenttatton Supervisor, a remote alarm quartterly ftor compliance annunciator for the each generator The date the systemic changes will was not provided in a location be completed: readily observed by operating The ftacilitty respectfully requestts a personnel at a regular work waiver tto exttend tthe datte certtain The esttmatted time oft correction is station such as a nurses' stations December 31, 2011. or any other area in the facility.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155688		(X2) MULTIPLE CO A. BUILDING B. WING	02	l` ´	e survey pleted /2011	
NAME OF PROVIDER OR SUPPLIER FREELANDVILLE COMMUNITY HOME			310 W (ADDRESS, CITY, STATE, ZIP CO CARLISLE ST ANDVILLE, IN47535	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	at 1:30 p.m., the Supervisor acknowere no remote annunciators for generator at the any other area. 3.1–19(b) 2. Based on obtinterview, the fensure 1 of 2 end generators was remote manual requires emerging providing power lighting system tested and mai accordance with Standard for Endersteed and mai accordance with	e nurses' station or in the facility. Diservation and facility failed to emergency equipped with a stop. LSC 7.9.2.3 dency generators er to emergency is shall be installed, intained in h NFPA 110, intergency and Systems. NFPA ion, 3–5.5.6 Il installations shall manual stop station ar to a break-glass elsewhere on the else the prime mover ide the building. Ilard for the Il Use of Stationary				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688			LDING	NSTRUCTION 02	(X3) DATE S COMPL 08/01/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	 	P. (12		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	NDVILLE COMMUN			1	CARLISLE ST ANDVILLE, IN47535		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	ANDVILLE, IN47555		(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	requires engin	es of 100					
	horsepower or						
	l ⁻	hutting down the					
	1	engine and from a					
		n. This deficient					
	l •	affect all residents,					
		ors and staff while nce Bay portion of					
	the facility.	ice bay portion of					
	the facility.						
	Findings includ	de:					
	Based on obse	rvation on					
	08/01/11 betv	veen 10:45 a.m. and					
	l ' '	ng a tour of the					
	facility with the	e Maintenance					
	Supervisor, no	evidence of a					
	remote shut of	f device was found					
	for the generat	tor. Based on					
	interview at 12	•					
		upervisor indicated					
		rator was over 100					
	l '	d was installed after					
		her indicated there					
		shut off device for					
	the generator.						
	3.1-19(b)						
	3. Based on ol	oservation and					
	interview, the f	facility failed to					
		site fuel source for					
	1 of 2 emerger	ncy generators was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CO			(X3) DATE SURVEY COMPLETED		
		155688		BUILDING	02		08/01/2		
		100000	B. V	VING			00/01/2	011	
NAME OF I	PROVIDER OR SUPPLIEF	3			DDRESS, CITY, STA	TE, ZIP CODE			
FRFFI Δ	NDVILLE COMMUN	NITY HOME			CARLISLE ST ANDVILLE, IN47	7535			
								(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX		LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LISC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCE DEF	ED TO THE APPROPRIAT ICIENCY)	E	DATE	
	from a reliable	source. NFPA 110,							
	1999 Edition, S	•							
	· · · · · · · · · · · · · · · · · · ·	d Standby Power							
		ter 3, Emergency							
		EPS), 3–1.1, Energy							
	Sources states								
		s shall be permitted							
		emergency power							
	supply (EPS):	emergency power							
		oleum products at							
	atmospheric p								
	•	etroleum gas (liquid							
	or vapor withd	- ·							
	c) Natural or s								
	Exception: For	•							
	•								
		locations where the							
	•	nterruption of off							
		es is high (e.g., due							
	• •	flood damage or							
		utility unreliability),							
	_	e of an alternate							
		sufficient to allow							
	full output of t	- ·							
		system (EPSS) to be							
		ne class specified							
	=	ed, with provision							
		ransfer from the							
	primary energy source to the								
	alternate energy source. CMS								
	=	nce of reliability of							
	the natural fue	l source must							
	contain all of t								
	a. A statement	t of reasonable							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	ZDIX2	21 Facility I	D: 000355	If continuation sh	neet Par	ge 45 of 47	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688		ULTIPLE CO LDING	NSTRUCTION 02	(X3) DATE COMPI 08/01/2	ETED
155000		B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/01/2	011	
NAME OF I	PROVIDER OR SUPPLIER				CARLISLE ST		
FREELA	NDVILLE COMMUN	IITY HOME		1	ANDVILLE, IN47535		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	reliability of the delivery;	e natural gas					
	b. A brief desc	rintion the					
		atement regarding					
	the	atement regarding					
	reliability;						
	c. A statement	there is a low					
	probability of i	nterruption of the					
	natural						
	gas;						
	d. A brief desc	ription that					
	supports the st	atement regarding					
	the low						
	-	of interruption;					
	e. The signatu						
	-	the natural gas					
	vendor.						
	=	oractice could affect					
	•	s well as visitors					
		in the Ambulance					
	Bay portion of t	the facility.					
	Findings includ	e:					
	_						
	Based on obser	vation on					
	08/01/11 at 11	1:25 a.m. during a					
	tour of the faci	· ·					
		ipervisor, the small					
	emergency gen						
	basement was						
	natural gas onl	-					
	_	by the Maintenance					
	Supervisor at th	ne time of					

000355

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPI	LETED
		155688	B. WIN			08/01/2	2011
NAME OF PROVIDER OR SUPPLIER FREELANDVILLE COMMUNITY HOME				STREET A	ADDRESS, CITY, STATE, ZIP CODE CARLISLE ST ANDVILLE, IN47535	1	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observation. E at 1:45 p.m. th indicated the f a letter from th	Ouring an interview ne Administrator acility did not have neir natural gas dence of reliability					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZDIX21

000355

Facility ID:

If continuation sheet

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